TENNESSEE DEPARTMENT OF HEALTH

WIC/SENIORS FARMERS' MARKET NUTRITION PROGRAM

Initial Application: Yes___No____

2020 FARMER APPLICATION FOR AUTHORIZATION TO PARTICIPATE IN THE TENNESSEE FMNP PROGRAM Only completed applications will be processed.	**FOR FMNP USE ONLY** **REG._____CO._____FARMER NO. _____** **Agriculture Ext. Agent _____** **Date Contacted _____** **Vendor Rep _____** **Date Application Rec'd Date Approved _____**

Follow instructions and mail to the Regional Office. Complete in ink or type.

PART I. FARMER IDENTIFICATION

1. FARMER'S NAME _____

2. FARM NAME_____

A. MAILING ADDRESS

Street/ P.O. Box _____

_____ City_____State_____Zip _____

Telephone Number: Area Code_____Number_____Fax: AC No. _____

E-mail address _____

B. FARM LOCATION (If different from above)

Street Address/Rural Route Number ___

_____ City _____

_____ County(s)

_____State_____Zip _____

3. CROPS INTENDED TO GROW_____

_____

4. LOCATION(S) OF MARKET(S) OR SELLING LOCATION(S)

Please list when and where you plan to sell produce.

LOCATION	DAY (Example M – F)	TIMES (Example 7 am – 6 pm)
1. _____	_____	
2. _____	_____	
3.	_____	

PART II. CONTACT INFORMATION

5. SECONDARY CONTACT PERSON

Name of person in authority when (or if) farmer is not present:

First Name_____Last Name _____

Street Number_____Street Name/P.O. Box _____

City_____State_____Zip Code_____Phone _____

PART III. VOUCHER REDEMPTION

6. BANK WHERE VOUCHERS WILL BE DEPOSITED

Bank _____

Branch Name _____

PART IV. STATEMENTS AND CERTIFICATION

PRIVACY ACT STATEMENT - The collection of this information is authorized by Part 248.20 of Federal Regulations 7CFR which governs the FMNP Program and by Part 249.20 of Federal Regulations 7 CFR which governs the Senior FMNP. It will be used to determine whether a farmer qualifies to participate in the FMNP Program; to monitor compliance with program regulations; and for program management. However, failure to provide information may result in the denial or withdrawal of authorization to participate in the FMNP Program. The purpose of collection of this information is for audit and enforcement of FMNP Program regulations.

WARNING STATEMENT - Information in this application may be verified with other agencies. FMNP Program participation shall be denied or withdrawn if any application information is false; in addition, you may be fined up to $10,000 or imprisoned for up to five years or both for concealing any material fact, making false statements or representation, or using any false writing or documentation in connection with the application.

CERTIFICATION AND SIGNATURE OF FARMER

1. **I apply for authorization to take part in the FMNP Program, and I have authority to enter into an agreement with the Tennessee Department of Health.**
2. **I understand that I will be responsible for understanding the requirements, policies, and procedures appearing in the Farmers' Market Handbook which is considered part of the Farmer's Agreement. This information shall be presented during both initial and follow-up training for authorization as a Farmers' Market Nutrition Program vendor. I further understand that I or another representative will have an opportunity to ask questions during the training sessions.**
3. **I am at least 18 years of age, reside and grow the crops listed on this application in the state of Tennessee. The information contained in this application is accurate and complete. I understand that violation of the rules may result in the loss of my privilege to participate in the program. I understand that a FMNP representative may verify the information provided on my application by visiting my farm.**

SIGNATURE_____**DATE** _____

PRINT NAME _____

DAYTIME PHONE NUMBER _____

COMPLETION OF THIS APPLICATION DOES NOT GUARANTEE AUTHORIZATION TO PARTICIPATE IN THE FMNP PROGRAM.

This institution is an equal opportunity provider.